



PATIENT

Cassidy Petrelecan

SPECIES

Canine

BREED

Miniature
Goldendoodle

SEX

Spayed Female

AGE

14 years

WEIGHT

16.4 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Betsy LaCroix

HOSPITAL NAME

Inspire AH Highlands
Ranch

REFERRING VET

Dr. Haskins

INVOICE

78792

DATE

6/17/26

PRESENTING CLINICAL SIGNS

History: Chronic intermittent GI signs- mainly diarrhea
Historical pancreatitis

History seizures and suspected encephalitis- well managed by neurology
medications- zenrelia, phenobarbital, zonisamide, metronidazole

Abnormal PE/Chem/CBC/UA Results: Cataracts, heart murmur, dental disease Fecal in house- neg
CBC- WNL VS- ALP 447 (chronic, likely secondary to phenobarbital), otherwise NSF UA- USG 1.036, pH
6, inactive sediment

The owner had given the dog's medication this morning in two pill pockets within an hour of the
ultrasound

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended, and the wall of the urinary bladder appears thin and smooth.
The urine is anechoic. The trigone and proximal urethra have a normal ultrasonographic appearance. No
calculi are identified, and there is no sonographic evidence of inflammatory or neoplastic disease.

The left kidney is normal in shape and size, measuring 3.79×2.28 cm, with a cortical thickness of 0.41 cm
in the sagittal plane.

The right kidney is normal in shape and size, measuring 4.12×2.24 cm, with a cortical thickness of 0.39
cm in the sagittal plane.

Both kidneys demonstrate normal cortical echogenicity. Corticomedullary distinction and
corticomedullary ratio are preserved. There is no evidence of pyelectasia, nephrolithiasis, or
hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. Dorsoventral diameters measured in
the sagittal plane are as follows:

- Left adrenal gland: 0.51 cm at the cranial pole and 0.53 cm at the caudal pole.
- Right adrenal gland: partially visualized; caudal pole measures approximately 0.49 cm.

Spleen

Splenic thickness is 1.06 cm. The splenic parenchyma demonstrates normal echogenicity and a fine
homogeneous echotexture. A small, well-defined hyperechoic splenic nodule measuring approximately
3.78×5.51 mm is identified, most consistent with a benign myelolipoma-like lesion. The splenic capsule
is smooth and regular.



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Liver

The liver is mildly enlarged with a regular contour. The hepatic parenchyma is mildly diffusely hyperechoic with a very fine echotexture and mild distal acoustic attenuation. The hepatic parenchyma also contains a few small, well-defined hypoechoic nodules measuring approximately 0.5 cm in diameter. No hepatic lymphadenopathy is observed.

The gallbladder is moderately distended. Mild gallbladder mucosal hyperplasia is present. A small to moderate amount of biliary sludge is identified within the lumen. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal tract

The stomach is empty and folded. Gastric wall thickness measures 2.07 mm, and normal wall layering is preserved. The pylorus measures 4.59 mm in thickness and maintains normal wall layering. The duodenum measures 4.09 mm in thickness and maintains normal wall layering. The jejunum measures 3.34 mm in thickness and maintains normal wall layering. The ileoceocolic junction measures 1.68 mm and has a normal ultrasonographic appearance. No evidence of gastrointestinal obstruction, ileus, foreign material, focal mural thickening, or loss of wall layering is identified. The colon measures 2.11–2.36 mm in thickness and contains very soft fecal material. Mild increased echogenicity of the adjacent colonic fat is present.

Pancreas

The pancreatic regions included in the examination do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Mild hepatomegaly with diffuse mild hepatic hyperechogenicity and acoustic attenuation.
- Early gallbladder mucosal hyperplasia with biliary sludge.

SECONDARY FINDINGS

- Subtle hyperechogenicity of the fat surrounding the colon.
- Small incidental splenic myelolipoma-like nodule.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild hepatomegaly, diffuse hepatic hyperechogenicity, and mild distal acoustic attenuation are present. In conjunction with the chronic ALP elevation and long-term phenobarbital administration, these



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findings are most consistent with chronic hepatocellular vacuolar change and/or drug-associated hepatopathy. The small hypoechoic hepatic nodules most likely represent areas of nodular hyperplasia or regenerative nodular change developing within a background of chronic vacuolar hepatopathy. These lesions arise from localized hepatocellular proliferation and remodeling associated with chronic metabolic or drug-induced hepatic change and are commonly encountered in geriatric dogs. Mild gallbladder mucosal hyperplasia and biliary sludge are likely related to the same chronic hepatobiliary process.

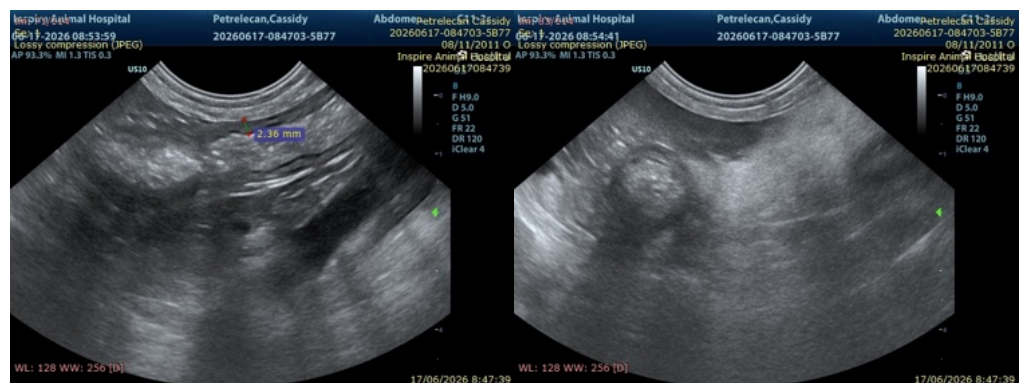
No convincing ultrasonographic evidence of active pancreatitis is identified at the time of examination. This does not exclude chronic or recurrent pancreatitis, particularly given the reported clinical history, as ultrasonographic abnormalities may be absent between episodes or during periods of mild disease activity.

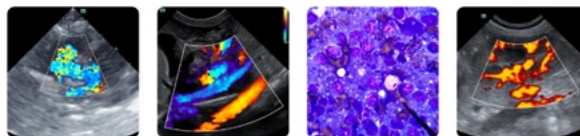
The colon contains very soft fecal material, and mild hyperechogenicity of the adjacent pericolic fat is present. Although these findings are subtle and nonspecific, they may reflect low-grade colonic inflammation or functional large bowel disease and are considered compatible with the patient's history of chronic intermittent diarrhea. Importantly, chronic inflammatory, dietary-responsive, functional, or microbiome-associated colonic disorders may produce limited or no significant ultrasonographic abnormalities.

Recommendations

- A gastrointestinal panel (cPLI, cobalamin, and folate) may be considered if not recently performed, particularly given the history of pancreatitis and chronic gastrointestinal signs.
- Fecal PCR testing and parasite screening (including Giardia, Cryptosporidium, whipworms, and other enteropathogens as regionally appropriate) may be considered if not recently performed.
- Dietary management remains an important consideration. Depending on previous dietary trials, a highly digestible, hydrolyzed, or novel-protein diet may be beneficial.
- Continued probiotic therapy may be reasonable based on clinical response.
- Serial monitoring of liver enzyme activities is recommended, particularly given the chronic phenobarbital administration.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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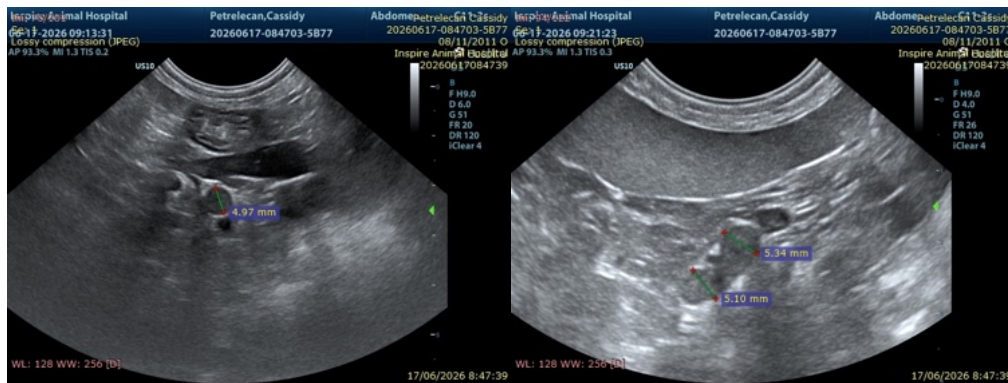
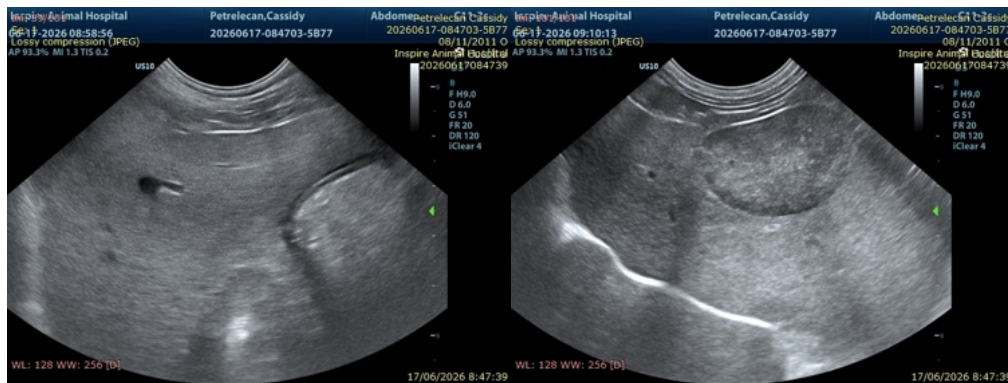
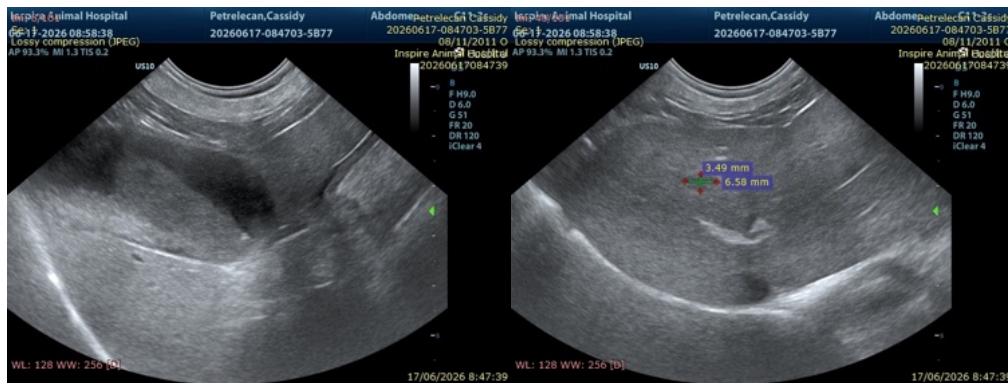
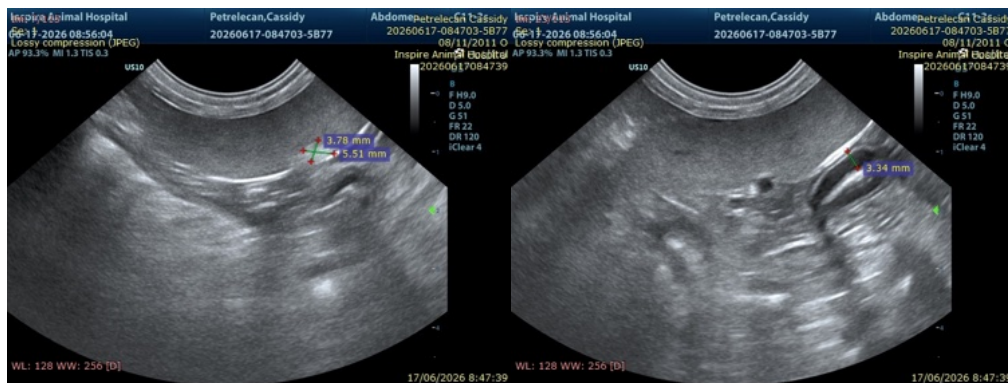
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

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